

FINDINGS OF FACT

Having reviewed the evidentiary record filed herein, the stipulations of the parties, and having considered the parties' briefs and oral arguments, the Board makes the following findings of fact and conclusions of law:

The claimant was employed as a grinder for the respondent foundry. On August 2, 2000, a supervisor requested claimant assist a co-employee to lift parts from one basket and place them in a bin. A hoist normally used to assist lifting the parts was not working and claimant and the co-employee were required to bend at the waist and lift parts that weighed 75-80 pounds. The parts were lifted by hand for approximately 15 minutes until the hoist began to work.

The claimant began to experience lower back pain after he got home from work that day. The next morning the claimant had lower back pain and experienced difficulty walking. He went to work, his shift began at 4 a.m., and reported the injury to his supervisor. Claimant was advised to see the plant nurse and so he went home and returned at 7 a.m. to see the nurse.

The nurse advised claimant he needed to urinate in a cup before he could go see the company doctor. Claimant wasn't able to urinate although he drank two glasses of water and made numerous attempts to provide a specimen. Claimant was finally referred to the company physician, Paul Sandhu, M.D., for treatment.

Dr. Sandhu examined the claimant and found tenderness in the lumbosacral area of the back but x-rays showed no acute changes. The neurological examination was normal. Dr. Sandhu opined claimant had an acute lumbar and thoracic sprain, prescribed Indocin for a week and imposed a 20-pound weight restriction which noted claimant could lift that weight 10 times per hour for a 12-hour shift.

Claimant returned to the plant nurse's office after seeing Dr. Sandhu and was again requested to provide a urine specimen before he could go home. Claimant tried for two more hours but was unable to provide a specimen. Claimant again offered to provide a blood sample but that offer was refused. The claimant then left the foundry and has not returned to work for respondent since that time.

On August 18, 2000, claimant saw Dawn McCaffery, a nurse practitioner with Dr. Sandhu. Ms. McCaffery examined the claimant and found that his mid back strain was not responding to treatment. Ms. McCaffery discontinued the claimant's Indocin and changed him to Naprosyn 500 mg. b.i.d. and one Soma at bedtime. Claimant was directed to apply ice and heat to his back and return for follow-up in a month.

On August 25, 2000, the claimant was again seen by Ms. McCaffery. Examination at this visit revealed claimant had the ability to reach his ankles with normal range of

motion. Straight leg raising was negative bilaterally. The claimant's mid back had improved and he was returned to work with a 40-pound weight restriction for 7 days. Claimant was to continue the same medications as before and return for a follow-up in one month. Claimant did not seek any further medical treatment.

Claimant testified that since the injury he has had pain in his lower back and the pain increases with bending, lifting, pulling and prolonged walking for greater than 30 minutes. The pain continues in the same area of his back with no radiculopathy into either leg. Claimant is currently a student at Coffeyville Community College.

The claimant testified that prior to the injury he had seen a chiropractor one time for upper back pain but had not had any other back problems. However, Terry Thompson, D.C., testified he had treated claimant on November 15, 1999, for complaints of low back pain with an onset one month prior. Claimant was diagnosed with a lumbosacral sprain. Dr. Thompson additionally treated claimant for the same complaints on December 20, 1999, and June 9, 2000. Claimant's personal physician, Paul Sandhu, M.D., also had treated claimant on December 20, 1999, for a complaint of low back pain which was diagnosed as lumbosacral strain.

Dr. Sandhu, the treating physician, noted claimant's examination on August 3, 2000, revealed tenderness in the lumbosacral area. X-rays showed no acute changes and the neurological examination was normal. Dr. Sandhu concluded claimant had suffered an acute lumbar and thoracic sprain.

When asked if claimant suffered either a permanent or temporary aggravation of his back condition when injured on August 2, 2000, the doctor responded that based upon the three office visits, he would tend to think the injury was more a sprain and muscular condition that got better. However, on the issue of permanency Dr. Sandhu agreed he would defer to the opinions of the physicians who examined claimant at a later date.

The claimant was referred by his attorney to Edward J. Prostic, M.D., for examination on November 6, 2000. Dr. Prostic testified the claimant denied previous difficulties with his back. Claimant had complaints of intermittent pain. Dr. Prostic found on physical examination the claimant had tenderness at the lumbosacral junction; slow but complete flexion and extension; one-third restriction of lateral bend to the right; some hamstring tightness bilaterally supine but not seated; and, mild disk space narrowing at L5-S1 on x-ray.

Dr. Prostic opined the mild disk space narrowing at L5-S1 was suspicious for degenerative disk disease at this level. Dr. Prostic diagnosed the claimant as having an injury to his low back most likely to the L5-S1 disk and agreed with Dr. Sandhu's diagnosis of back sprain at that level.

Dr. Prostin opined the claimant's injury was caused by the incident at Acme Foundry. Dr. Prostin placed the following restrictions on the claimant: (1) lift only up to 50 pounds occasionally, 20 pounds frequently and 10 pounds constantly; (2) avoid frequent bending or twisting at the waist, forceful pushing or pulling; and, (3) minimal use of vibrating equipment or captive positioning.

Based upon the AMA Guides, Fourth Edition, Dr. Prostin opined the claimant sustained an 8 percent permanent partial impairment of the body as a whole on a functional basis due to his work-related injury on August 2, 2000. Dr. Prostin used the range of motion model and for the degenerative disk disease claimant received a 7 percent and a 1 percent for the loss of lateral bend. Dr. Prostin testified claimant is between the 5-8 percent depending on whether the DRE model or the range of motion model is used.

Dr. Prostin agreed that the degenerative disk condition revealed on x-ray predates the August 2, 2000, accident and further agreed that the fact claimant last sought medical treatment on August 25, 2000, is indicative claimant did not suffer a terrible accident. Because Dr. Prostin examined and rated claimant three months after the accident, he agreed he would not diagnose claimant with chronic back pain at that time.

The claimant was referred by respondent to Philip Roderick Mills, M.D., for examination on February 21, 2001. Dr. Mills conducted a physical examination of the claimant and concluded claimant had an underlying preexisting degenerative disk disease with temporary aggravation due to the accident on August 2, 2000. Dr. Mills testified the claimant has a DRE Lumbosacral Category I impairment which results in a zero percent permanent impairment. Dr. Mills recommended for the claimant to use good body mechanics.

CONCLUSIONS OF LAW

Claimant bears the burden of proof to establish his right to an award of compensation and to prove "the various conditions on which the claimant's right depends."¹ The Board must consider the entire record to determine whether claimant has satisfied the burden of proof. The Workers Compensation Act defines the terms "burden of proof" as "the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true."²

¹K.S.A. 44-501(a).

²K.S.A. 44-508(g); see also, Chandler v. Central Oil Corp., 253 Kan. 50, 57, 853 P.2d 649 (1993).

The Board, as a trier of fact, must decide which testimony is more accurate and/or more credible and must adjust the medical testimony along with the testimony of the claimant and any other testimony that might be relevant to the question of disability.³

The claimant suffered a work-related injury on August 2, 2000, and was provided medical treatment with Dr. Sandhu. After three office visits the claimant did not return for any further treatment. Dr. Sandhu, on the basis of the claimant's three office visits, concluded claimant had a temporary back sprain which had improved. This opinion was confirmed by Dr. Mills, the last physician to examine claimant. Dr. Mills noted the fact claimant had prior low back problems confirmed his opinion claimant would have episodes of temporary aggravation to his low back which would resolve. Dr. Mills concluded claimant suffered a temporary aggravation with no permanency as a result of the accident on August 2, 2000.

Conversely, Dr. Prostic concluded claimant had suffered an 8 percent permanent impairment to his low back caused by the August 2, 2000, accident. However, as the Administrative Law Judge noted, this opinion was rendered only three months after claimant's accident. Dr. Prostic also rendered his opinion at a time when he admitted claimant's condition was not chronic. Lastly, Dr. Prostic noted the fact claimant had not sought treatment after August 25, 2000, was an indication claimant had not suffered a terrible accident.

There are troubling aspects with the testimony of both Drs. Mills and Prostic. A portion of Dr. Mills' testimony, if taken out of context, could be construed to indicate the doctor did not assign an impairment rating to claimant merely because claimant was a teenager and might in the future suffer additional permanent impairment. However, after making those comments the doctor concluded claimant appropriately fit DRE Category I and had not suffered any permanent impairment.

Dr. Prostic assigned a permanent impairment percentage at a time he agreed claimant's condition was not chronic, which could imply claimant was not at maximum medical improvement. The doctor further candidly admitted his use of either the DRE categories or range of motion to arrive at his impairment rating was dependent upon whether he was providing expert testimony for the respondent or the claimant.

In any event, the examining doctors made minimal objective findings upon their examinations of the claimant. After the accident the claimant only had three office visits for treatment and then sought a permanent impairment rating. The Board concludes Drs. Sandhu and Mills' opinions that claimant had suffered a temporary aggravation of an underlying degenerative condition is the more persuasive assessment of claimant's condition. The claimant has failed to establish he suffered any permanent impairment as

³Tovar v. IBP, Inc., 15 Kan. App. 2d 782, 817 P.2d 212, rev. denied 249 Kan. 778 (1991).

a result of his work-related accident on August 2, 2000. Accordingly, the Administrative Law Judge's Award is affirmed in all respects.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Jon L. Frobish dated July 24, 2001, is affirmed.

IT IS SO ORDERED.

Dated this _____ day of May 2002.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: William L. Phalen, Attorney for Claimant
Paul M. Kritz, Attorney for Respondent
Jon L. Frobish, Administrative Law Judge
Philip S. Harness, Workers Compensation Director